

Dear Representative,

As the House and Senate work toward a final version of SB 557-FN, I write to request that you amend the immediate effective date of this ban. While the goal of protecting public health is legitimate and shared, abruptly criminalizing a substance relied upon by thousands — without a medical tapering period — may inadvertently create a serious public health crisis. Since the Committee of Conference has not yet been named, I respectfully ask that you forward this letter to the conferees once they are appointed.

The State's Contract with Our Veterans

When citizens deploy to war, there is an implicit social contract: the state asks for everything, even their lives, and in return promises to make them whole if they survive. But for veterans suffering from chronic pain and invisible wounds, our institutions have historically been slow to respond. The record speaks for itself. PTSD took nearly a century to validate. In Vietnam, the VA denied Agent Orange cancers for decades — most eligible veterans died before the policy changed. Gulf War illness was called "psychological" for years while veterans deteriorated. Burn pit exposures in Iraq and Afghanistan killed thousands before the PACT Act finally passed in 2022. This pattern is documented and repeated: by the time the state acts, it is often already too late.

Because conventional medicine has often fallen short — either failing to control their pain or causing harmful side effects — many veterans have turned to kratom and 7-Hydroxymitragynine (7-OH). To take this away overnight would risk breaking the trust that the contract depends on and it would do so in a state already in the grip of a severe and worsening suicide crisis.

New Hampshire's Existing Suicide Crisis

In 2024, New Hampshire's age-adjusted suicide rate was 16.4 deaths per 100,000 — 20% above the national average of 13.7. Over two decades, our rate surged 65.7% while the nation rose only 24.5%. (USAFacts, citing CDC WONDER and the National Vital Statistics System)

Coos County's age-adjusted suicide rate is 25.0 per 100,000. Carroll County: 19.9. These are the same rural communities where veterans disproportionately live and where behavioral health resources are most scarce. Between 2016 and 2022, 17% of all NH suicide deaths involved current or prior military service. In New Hampshire, 88% of all gun deaths are suicides, not homicides. A firearm attempt is fatal approximately 90% of the time. SB 557-FN contains no transition period and no medical bridge. (County rates: HDPulse/NIMHD 2019-2023. Veteran figure: NAMI NH, as cited in Valley News 2025. Gun death figure: EveryStat. Firearm fatality rate: Johns Hopkins Center for Gun Violence Solutions)

The Science of Abrupt Cessation

A 2020 study by Oliva et al. published in The BMJ followed 1,394,102 patients in the Veterans Health Administration who held outpatient opioid prescriptions between October 2012 and

September 2014. Among those patients, 2,887 deaths from overdose or suicide were identified. Stopping opioid treatment was associated with an increased risk of death regardless of how long patients had been treated, with risk growing the longer treatment continued. Hazard ratios for patients who stopped were 1.67 for those treated 30 days or fewer, 2.80 for 31-90 days, 3.95 for 91-400 days, and 6.77 for those treated more than 400 days. Death rates increased immediately after stopping, decreasing only over approximately three to twelve months. The authors concluded: "Patients were at greater risk of death from overdose or suicide after stopping opioid treatment, with an increase in the risk the longer patients had been treated before stopping." They further noted that "strategies to mitigate the risk in these periods are not currently a focus of guidelines for long term use of opioids," and called for addressing "factors that place patients at risk for overdose or suicide after beginning and stopping opioid treatment, especially in the first three months." (Oliva et al., BMJ 2020;368:m283)

A NBER working paper by Tibbitts and Cowan examined the VA's Opioid Safety Initiative, which substantially restricted veterans' opioid prescriptions. Before the initiative, veteran and civilian suicide trends ran parallel. After implementation: "the suicide rate for veteran/military personnel increases relative to the civilian rate, and this effect is concentrated among rural veterans. In the year of implementation (2013), rural veteran suicides increased roughly one-third of the pre-treatment mean relative to the base group (urban civilians); this effect was 37% in 2018. Urban veterans also experienced statistically significant increases in suicides starting in 2015 on the order of 13-21 percent." (Tibbitts & Cowan, NBER Working Paper No. 29139)

The parallel to SB 557-FN is direct. Though 7-OH is not a prescription drug, it acts on the same mu-opioid receptors as prescription opioids, producing similar physical dependence and a similar withdrawal syndrome upon abrupt cessation. What the bill would set in motion is functionally analogous to what the NBER study measured: a sudden, policy-driven restriction on an opioid-acting substance, with no transition period, on a veteran population already over-represented in our state's suicide data, in rural counties already recording the state's highest mortality rates.

Testimony on the Consequences of a Ban

Dr. Michele Ross, an addiction scientist and leading researcher on 7-OH, submitted testimony during committee hearings stating that making 7-OH a Schedule I substance "will leave consumers 3 options—suffering, street drugs, or suicide." Her study of 1,521 7-OH consumers found that 17% reported they would consider suicide if 7-OH were banned, and 25% said they would obtain opioids such as fentanyl or heroin from the illicit market. She noted that 74% of consumers use these products for chronic pain, and 8% are veterans managing chronic pain and PTSD. Dr. Ross urged the committee to regulate rather than ban, including age-gating, serving size caps, and adulterant testing. (Remote Testimony by Ross, Michele (Plano, TX) — Oppose, House Criminal Justice and Public Safety, April 8, 2026)

Kratom's Pain Relief Is Dependent On Its Conversion By The Liver Into 7-OH

I want to offer a clarification regarding the pharmacology of kratom that may be useful as the committee finalizes the bill's language. During floor debate, it was suggested that restricting 7-hydroxymitragynine concentration would leave pain-relief products unaffected, because 7-OH becomes dangerous only at high concentrations. Peer-reviewed research provides important context. A 2024 study by Mongar et al. in *ACS Pharmacology & Translational Science* found that "CYP3A4 conversion was found necessary for the analgesic effects of mitragynine in healthy volunteers" (Mongar et al., *ACS Pharmacol. Transl. Sci.*, 2024, PMC10928879). In other words, the human body itself converts the main alkaloid in plain kratom leaf (mitragynine) into 7-OH to produce pain relief. That same study reported that "the median ratio of AUC₇₂ of 7OH to AUC₇₂ of mitragynine in our study (13.25 ± 1.07 , Table 1) reflected an efficient conversion of mitragynine to 7OH in humans, compared to those recently reported in rats (1.4 ± 0.2)." This finding confirms that the human body actively and efficiently produces 7-OH in pharmacologically meaningful amounts—a dynamic the committee may wish to weigh carefully as it considers dosage thresholds.

Further, a 2020 study by Kamble et al. demonstrated that in human plasma, 7-OH is rapidly converted into mitragynine pseudoindoxyl (MP) at a rate 53 times higher in humans than in the animal models previously used to assess risk (Kamble et al., *ACS Pharmacol. Transl. Sci.*, 2020, PMC7737207). Notably, MP is currently the subject of federally funded research as a potentially safer analgesic. NIH Project Number 5R33DA045884 identifies MP as a "biased mu agonist towards G-protein transduction systems" showing "reduced respiratory depression, tolerance and dependence." The Principal Investigator describes this scaffold as "an excellent starting point for developing analgesics with a superior side effect profile to all clinically used mu opioid analgesics." (NIH Project Number 5R33DA045884, "Pharmacological Probes based on mitragynine pseudoindoxyl," Majumdar S, Sames D, St. Louis College of Pharmacy, 2018–2020)

I raise this not to criticize any prior statement, but to ensure the committee has the full pharmacological picture—including the body's own metabolic pathways—as it decides on final concentration limits and whether to exempt naturally occurring compounds.

The Mortality Data Regarding Kratom & 7-OH

I want to provide the committee with additional context on the mortality data that has been cited during the bill's consideration, so that the final decision rests on the fullest available picture.

The Ohio Department of Health reported 202 deaths in which kratom was listed as a cause of death between 2019 and 2024. The same data appendix that produced that figure—Figure 2 of the Ohio Board of Pharmacy's own rulemaking record—also shows that of the 255 total deaths where kratom was detected in postmortem toxicology, 217, or 85.1%, were positive for other substances such as fentanyl or heroin. In 2022, that polysubstance involvement rate reached 93.6%. Those 202 deaths represent 0.9% of the 26,471 total unintentional overdose deaths in Ohio during the same period. (Ohio Board of Pharmacy, "Classification of Mitragynine-Related Compounds as Schedule I Controlled Substances," Figure 2, 2019–2024.)

A similar pattern appears in CDC data. An April 2019 MMWR examining overdose deaths in 27 states found that kratom-positive deaths accounted for less than 1% of all overdose deaths, and that 65.1% of deaths where kratom was determined to be a cause also involved fentanyl or its analogs. The CDC concluded that "kratom was present primarily in deaths that occurred as a result of overdoses related to substance misuse and that kratom was most often detected in combination with multiple other substances." (Unintentional Drug Overdose Deaths with Kratom Detected — CDC MMWR, Vol. 68, No. 14, April 12, 2019)

More recently, the Los Angeles County Department of Public Health reported six deaths tied to 7-OH in October 2025. Its own news release stated: "Alcohol was present with 7-OH in many of the fatal overdose cases, in addition to other medications and, at times, illicit substances." (Los Angeles County Department of Public Health News Release, October 10, 2025)

As of August 2025, independent legal analysis by Venable LLP concluded that "there are no confirmed cases of fatalities from 7-hydroxymitragynine alone." The firm noted that this evidence base "distinguishes the current situation from previous emergency scheduling actions, where the DEA responded to patterns of multiple deaths, substantial law enforcement submissions, and notable increases in emergency department visits," and warned that relying primarily on preclinical animal research "marks a substantial shift from the established legal approach, which prioritizes real-world evidence of urgent public health risks." (Todd A. Harrison and Alexander S. Rubel, Venable LLP, "FDA Announces Plan to Restrict 7-OH Opioid Products," August 12, 2025)

I present this pattern not to minimize any loss of life, but to ensure the committee understands that the overwhelming majority of deaths in which kratom or 7-OH was detected also involved substances known to cause respiratory failure, particularly fentanyl. Understanding this distinction is essential to crafting a policy that targets the actual drivers of fatal overdose.

Reliability of the Surveillance Data

The State's justification for scheduling 7-Hydroxymitragynine relies on data from the FDA Adverse Event Reporting System (FAERS) and Poison Control Center call logs. Both are passive surveillance systems that accept anonymous, unverified, and self-reported submissions. The FDA itself cautions that FAERS reports "are not verified" and "a causal relationship cannot be established" from them alone. The agency explicitly warns that the data cannot be used to calculate incidence rates or compare drugs because reports may be influenced by media attention, litigation, or advocacy campaigns. Similarly, poison center exposure calls are not confirmed overdoses; they are voluntary calls often based on caller self-diagnosis without toxicological confirmation. Nationwide, the overwhelming majority of kratom-related fatalities cited by the State involve polysubstance findings—especially fentanyl—making attribution to 7-OH alone scientifically unsupportable without verified postmortem toxicology. I respectfully encourage the committee to weigh these known limitations when evaluating the surveillance data, and to consider whether independent verification of a causal public health risk exists before according it significant weight in the bill's justification.

A Question the Public Record Answers: How Easy Is It to Make Concentrated 7-OH?

During testimony, Senator Abbas asked Dr. Cornel Stanciu how difficult it is to convert natural leaf into concentrated forms and whether the process increases potency. Dr. Stanciu confirmed that extraction concentrates alkaloids and that chemical processes can modify compounds. The question of how easy it is, however, may be best answered by the public record. (New Hampshire Senate Judiciary Committee, SB 557-FN Hearing Record, February 10, 2026)

For more than a year, the YouTube channel Kalifornia Kratom has hosted step-by-step instructional videos on exactly these processes—kratom extract (11,979 views as of May 2026), 7-hydroxymitragynine via catalytic oxidation (50,234 views), and 7-OH via the Oxone method, described as "how most manufacturers make 7-OH" (8,434 views). That is over 70,000 views. The methods use readily available solvents (methanol, acetone, ethyl acetate), common reagents (Oxone, baking soda, ammonia, sodium hydroxide), and equipment available online for under \$100, sold alongside household chemicals at hardware and grocery stores.

This raises a practical concern that I believe the committee should weigh carefully. Banning 7-OH will not make it disappear; it risks shifting production into home and black-market operations where there are no purity standards, no age restrictions, and no regulatory oversight. Home chemistry carries documented risks of toxic solvent contamination—methanol, hexane, and ethyl acetate are poisonous if not fully removed. Potency would be uncontrolled and unlabeled, increasing the likelihood of accidental overdose. I ask the committee to consider whether an unregulated, illicit supply poses a greater public health threat than the regulated commercial products the bill seeks to restrict.

7-OH Pricing

Senator Altschiller presented several retail products purchased locally — a \$10 single tablet, a \$9.99 drink, a \$6 candy cone, a \$40 five-pack of high-potency tablets, and other items — and noted that some users report spending hundreds or even thousands of dollars per month. (New Hampshire Senate Judiciary Committee, SB 557-FN Hearing Record, February 10, 2026) These figures reflect retail convenience-store pricing. The committee may also wish to be aware that an online bulk market exists where the same substance is available for as little as \$1 per 20mg dose—for example, the online vendor Bulk Kratom Capsules (pricing verified May 2026; cited here as a factual price reference, not an endorsement). For many responsible consumers, including veterans on fixed incomes, a single daily dose at that price manages their symptoms entirely. Considering both retail and bulk pricing would give the committee a more complete picture of the financial impact on regular users and the diversity of those who rely on these products.

Concerns Regarding a Transition to Buprenorphine

I recognize that buprenorphine is an important, evidence-based tool in addiction medicine and has helped many individuals achieve stability. However, I urge the committee to consider the risks of a sudden, policy-driven transition—without patient choice, informed consent, or

adequate support—for a population that did not seek addiction treatment and may not meet the clinical criteria for medication-assisted treatment.

First, real-world retention data warrant caution. A 2021 study in primary care (Bailey et al., *Journal of Substance Abuse Treatment* 131 (2021) 108548) found that only 18% of patients initiated on buprenorphine for opioid use disorder were retained at six months. The authors note this pattern is consistent across studies. The consequences of this high attrition are severe. A 2017 systematic review and meta-analysis by Sordo et al. (*BMJ* 2017;357:j1550) examined mortality during and after opioid substitution treatment with buprenorphine. The study found that all-cause mortality was more than twice as high out of treatment compared to in treatment (pooled rate ratio 2.20, 95% CI 1.34 to 3.61). Overdose mortality followed the same pattern, and the time immediately after leaving treatment was identified as a period of particularly elevated risk. For patients stable on 7-OH, the bill would force an abrupt discontinuation—without the clinical tapering, monitoring, and support that accompany a voluntary medical transition. Many may then be directed onto buprenorphine, a treatment they did not seek. Given the high-attrition pathway described above, a substantial portion will exit buprenorphine as well. At that point, they would be exposed to the documented post-buprenorphine mortality spike.

Second, I believe patients deserve full disclosure of the medication's risks before a transition is imposed. The FDA issued a safety warning in 2022 linking buprenorphine film to severe and potentially irreversible dental injury. An ongoing multi-district litigation (MDL No. 3092, Northern District of Ohio) now involves thousands of plaintiffs alleging these specific harms were not adequately disclosed. Regardless of the litigation's ultimate merit, the volume of claims suggests that many patients were surprised by side effects they did not anticipate. Any state-mandated transition should be accompanied by robust informed consent so that patients understand this risk.

Third, the corporate history of Suboxone's marketing warrants transparency. In 2019, the U.S. Department of Justice obtained a \$1.4 billion settlement—the largest opioid-related recovery in U.S. history—from Reckitt Benckiser Group for fraudulent marketing practices. The settlement resolved allegations that the company falsely marketed Suboxone film as less abusable and safer around children than tablet versions, claims that were never substantiated; that it fraudulently discontinued the tablet form to delay generic competition; and that it used a patient support program called "Here to Help" to connect vulnerable patients to doctors it knew were prescribing opioids at high doses, to more patients than allowed, and in a careless and clinically unwarranted manner. (Justice Department Obtains \$1.4 Billion from Reckitt Benckiser Group, U.S. Department of Justice Press Release, July 11, 2019) While this history does not diminish the medication's legitimate medical use, it underscores the importance of ensuring that any push toward buprenorphine is driven by clinical evidence and patient need, not by institutional or commercial momentum.

Fourth, there is a fundamental mismatch between the patient population and the proposed treatment. The vast majority of 7-OH consumers use the substance for chronic pain, not opioid use disorder. Notably, a 2024 national guidance document from the Department of Veterans Affairs states: "While evidence supports using buprenorphine for OUD as a lifelong/lifesaving

treatment, the use of buprenorphine for chronic pain treatment is not evidence-based." The same guidance recommends that when buprenorphine is used for pain, it should be "at the lowest dose and for the shortest duration necessary" (VA Pharmacy Benefits Management Services & National Formulary Committee, Buprenorphine for the Management of Chronic Pain, August 2024). Directing chronic pain patients—many of them veterans—toward a treatment that the VA itself does not consider evidence-based for their condition risks substituting one unapproved approach with another, without addressing the underlying need.

I raise these points not to oppose buprenorphine as a treatment option for those who choose it, but to highlight the risks of a sudden, state-mandated transition without patient consent, adequate disclosure, and long-term support. The committee may wish to weigh whether the bill should include a transition period, informed consent requirements, and bridge services before directing thousands of New Hampshire residents toward a treatment pathway with its own significant challenges.

Conclusion

I recognize that the bill was drafted in response to genuine public health concerns, and I share those concerns. However, additional information that has come to light since the floor debates—particularly regarding the pharmacology of 7-OH, the composition of the mortality data, and the forced-cessation risks documented in the VA population—suggests that the bill in its current form may have unintended consequences that we can still address before final passage.

Requested Actions for the Committee of Conference

To protect New Hampshire citizens from the unintended consequences of abrupt cessation, I urge the Committee of Conference to adopt the following two safeguards:

Extend the Effective Date. Delay the ban's implementation by at least 90 to 180 days. This window gives consumers—many of whom are veterans managing chronic pain—time to consult medical professionals and taper safely rather than being forced into abrupt withdrawal.

Provide Tapering Guidance. Require the Department of Health and Human Services to issue clinical tapering guidelines before the ban takes effect. No citizen should be left to navigate withdrawal alone or without medically sound direction.

The goal of protecting public health is one we all share. I believe that goal can be met while also safeguarding the thousands of New Hampshire residents—particularly our veterans—who have come to rely on these products. A brief delay in the effective date and the issuance of clinical tapering guidance would ensure that no one is forced into abrupt withdrawal without medical support. These two measures do not undermine the bill; they protect the very people the bill intends to help.

I respectfully ask that you forward this letter to the members of the Conference Committee when they are named, and that the committee give serious consideration to including these two

safeguards in the final version of SB 557-FN. Thank you for your time, your service, and your willingness to get this right.

Respectfully,
Anonymous